805 CMR: GROUP INSURANCE COMMISSION
Current through May 10, 2013

Chapter 1.00. General Provisions

§ 1.01 Authority

805 CMR 1.00 through 9.00 is promulgated in accordance with the authority granted to the Group insurance Commission by M.G.L. c. 32A and c. 32B, § 19.

(1) Administrative Bulletins. The Group Insurance Commission may issue administrative informational bulletins that provide the following:

(a) set out policies that are consistent with the substantive provisions of the Commission's regulations;

(b) specify the information and documentation necessary to implement the regulations;

(c) provide interpretations of the regulations; and

(d) to assist persons subject to the regulations to meet their obligations.

(2) Severability. The provisions of 805 CMR 1.00 through 9.00 are severable. If any provision or the application of any provision is held to be invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 805 CMR 1.00 et seq. or the application of such provisions.

§ 1.02 Definitions

As used in 805 CMR 1.00 through 9.00, the terms below have the following meanings:

Additional (Optional) Life Insurance. Commission-sponsored Term Life and Accidental Death and Dismemberment Insurance, based upon a State Employee's annual compensation and age, for which State Employees and State Retirees pay the full premium cost and which is in addition to the Basic Life Insurance.

Annual Enrollment. The period in which eligible insured and uninsured persons may enroll themselves and their Dependents in the Commission's benefit programs or make changes to their status or benefits in those programs that become effective on July 1st.

Basic Life Insurance. Commission-sponsored Term Life and Accidental Death and Dismemberment Insurance, for which eligible Employees and Retirees pay a portion of the premium cost and the Commonwealth pays the premium balance.

Calendar Month. For the purpose of premium payments and Commission coverage, a full month, e.g., March 1st through March 31st.

Child. 1) A son or daughter by birth or legal adoption (including any probationary period); 2) a minor placed in an adult's custody pursuant to an order from a court of competent jurisdiction, including a guardianship order; or 3) a person who is dependent upon another person for support and who lives in that other person's household, where there is evidence of a parent-child relationship satisfactory to the Commission, up to age 26 or two years after the child ceases to be an IRS dependent, whichever occurs first.

COBRA. Consolidated Omnibus Budget Reconciliation Act.

Commission. The Commonwealth of Massachusetts Group Insurance Commission.

Contributory Insurance. Insurance for which Employees and Retirees pay part of the premium and the Employer or the Commonwealth pays the premium balance.

Continuation Coverage. Federal and state non-group coverage, including COBRA and conversion coverage, available to those who were formerly Insureds but whose eligibility for group insurance coverage through the Commission has ended.

Deferred Retirees. Former Employees whose employment has terminated and who have vested rights to a retirement allowance, currently deferred, relating to their employment. Persons receiving a pension or retirement allowance whose monies are withdrawn or transferred to a non-participating retirement system are not Deferred Retirees. Otherwise qualified Former Municipal Employees may only be Deferred Retirees for as long as their Municipal Employer continues to offer insurance to Municipal Insureds through the Commission.

Dental and Vision Benefits. Dental benefits for certain preventive and other non-preventive dental care, and vision benefits for certain preventive vision care, products and services, available to eligible Insureds pursuant to § 9.22.

Dependent.

(a) A Spouse of an insured Employee or Retiree;

(b) A Former Spouse of an insured Employee or Retiree entitled to coverage pursuant to M.G.L. c. 32A, § 11A or M.G.L. c. 32B, § 9B, 9D, 9D½, and 9D¾;

(c) Up to age 19, or two years after ceasing to be an IRS dependent, but only to age 26, the Child of:

1. an insured Employee or insured Retiree;

2. an Employee's or Retiree's insured Spouse or insured Surviving Spouse; or

3. an Employee's or Retiree's insured Former Spouse, to the extent the Child was born prior to the date the divorce became final.

(d) Up to age 26, the IRS dependent of an insured Employee, Retiree, or Surviving Spouse;

(e) Up to age 26, a person who was previously an IRS dependent of an insured Employee, Retiree, or Surviving Spouse, for two years after ceasing to be an IRS dependent;

(f) The Child of a person who is eligible as a Dependent under paragraph (c), (d), or (e), above;

(g) A Child who is dependent upon an insured Employee, Retiree, or Surviving Spouse for support and who lives in the Employee, Retiree, or Survivor's household, where there is evidence of a parent-child relationship satisfactory to the Commission, up to age 26 or two years after the child ceases to be an IRS dependent, whichever occurs first;

(h) A Student who is the Child of an insured Employee or Retiree, or of an insured Employee's or Retiree's Spouse, Surviving Spouse or Former Spouse, and that Student's Children, if any;

(i) A Handicapped Dependent as defined in this section;

(j) A Child of an insured Employee, Retiree, Spouse, Former Spouse, or Surviving Spouse, up to age 26.

Elderly Governmental Retirees. Employees who: a) retired from the Commonwealth or one of its political subdivisions before January 1, 1956 or who retired from a city, town, or district that has accepted M.G.L. c. 32B, § 11B and were pensioned before that city, town, or district accepted M.G.L. c. 32A, § 10B; and b) are eligible for separate insurance coverage under the provisions of M.G.L. c. 32A, § 10B.

Emergency Employment. Employment for an unforeseen Employer emergency, limited to a specified time period, usually not more than 30 days.

Employee. Person whose time is devoted to the service of the Commonwealth or one of its political subdivisions that is authorized to participate in Commission benefit programs by express reference in state law, who works during the Regular Work Week of permanent employees and who contributes to a State pension system, a Housing, Redevelopment or Optional Retirement Plan, or another public sector retirement system; or a person elected by popular vote to state or local government office during the term that he or she holds office. State and municipal board, commission or authority members who do not work a Regular Work Week and its requisite statutory hours are not Employees unless expressly otherwise authorized by law. Contributions to an OBRA Plan do not constitute contributions to a public retirement system.

Employer. The Commonwealth or one of its political subdivisions that participates in certain Commission benefit programs by express statutory authority.

Family Health Coverage. Commission health coverage that includes a person entitled to and enrolled in Commission coverage and his or her eligible dependents.

Former Spouse. A person who was formerly married to an Employee or Retiree and who has been granted a judgment of divorce or of separate support.

Group Insurance Coordinator. The person at each reporting location who acts as a liaison between the reporting location and the Commission on matters involving the employer's and its employees' participation in the Commission's programs.

Half-time, Half-time Employees. Active employees who work at least 18.75 hours in a regular work week of 37.5 hours, or 20 hours in a regular work week of 40 hours.

Handicapped Dependent. A Child of an insured Employee, Retiree or Surviving Spouse, aged 19 or older, who:

(a) upon attaining age 19, was mentally or physically disabled and incapable of earning his or her own living;

(b) earns an annual income of less than 200% of the Federal Poverty Level; and

(c) if enrolling after age 26, other than as the Dependent of a new Enrollee, demonstrates satisfactory proof of involuntary loss of other coverage.

Health Care Spending Account. A pre-tax program through which active State Employees who work at least Half Time pay through payroll deduction on a pre-tax basis for non-covered health-related expenses.

Health Coverage, Health Insurance. Health benefits provided by the Commission to eligible Employees and Retirees and their eligible dependents pursuant to M.G.L. chs. 32A and 32B.

Individual Health Coverage. Health Coverage for a person entitled to and enrolled in a Commission health plan.

Insured. An Employee, Retiree, Survivor, or Dependent eligible for and enrolled in Commission coverage.

Local Governmental Unit. A county, city, town or district that participates in the Commission's Retired Municipal Teacher program.

Long-term Disability Insurance. An income replacement program that qualifies a State Employee to receive a percentage of his or her gross monthly salary, tax-free, after illness or injury renders him or her unable to work for more than 90 consecutive days.

Municipal Employee, Retiree, Survivor, or Dependent. An Employee, Retiree, Survivor, or Dependent whose eligibility for Health Coverage derives from employment or prior employment with a Municipal Employer.

Municipal Employer. A Massachusetts county, city, town or district that is an Employer by virtue of having formally agreed or obtained an order to transfer its Employees, Retirees, Survivors, and Dependents to Commission Coverage pursuant to M.G.L. c. 32B, § 19 or § 23, including the city of Lawrence, to the extent it is deemed to have accepted M.G.L. c. 32B, § 19, per St. 2010, c. 58, § 4(f).

Municipal Insured. A Municipal Employee, Retiree, Survivor, or Dependent eligible for and enrolled in Commission coverage.

Nondiscriminatory Basis. Plans whose coverage does not contain any annual or lifetime dollar or unit of service limitation imposed for care provided by one type of participating provider that is less than any annual or lifetime dollar of unit of service limitation imposed on coverage for the same services by other types of participating providers.

Nurse Practitioner. A Massachusetts licensed registered nurse in good standing who holds authorization in advanced nursing practice as a nurse practitioner under M.G.L. c. 112 § 80B.

OBRA Plan. A deferred compensation plan that serves as an alternative to Social Security as permitted by the federal Omnibus Budget Reconciliation Act of 1990, (PL101-508, 104 Stat. 1388).

Physician Assistant. A registered Massachusetts physician assistant in good standing who is supervised by a registered physician in accordance with M.G.L. c. 112, §§ 9C through 9K.

Regular Work Week. An employee's work, in the service of an Employer of no fewer than 18.75 hours, regularly, in a position for which the established work week is 37.5 hours or no fewer than 20 hours, regularly, in a position for which the established work week is 40 hours, or which meets other statutory requirements. Such hours averaged over any period of time do not constitute a Regular Work Week.

Retiree. A person formerly in the service of the Commonwealth or one of its political subdivisions that is authorized to participate in Commission benefit programs by express reference in state law, whose services ended on or after January 1, 1956 and who are eligible for and are receiving and continue to receive a retirement or pension allowance from a participating retirement system, including from the Board of Higher Education's Optional Retirement Program, but excluding any OBRA Plan.

Retired Municipal Teachers. Retired teachers of political subdivisions of the Commonwealth that have accepted M.G.L. c. 32B, § 11E, whose applications for coverage are approved by the Commission and who receive a pension from the State Teachers' Retirement Board and who are not eligible for Elderly Governmental Retiree coverage.

Retirement. A status that entitles a former Employee to a pension or retirement allowance under any general or special law, either at the time of employment termination or at some future date.

Seasonal Employment. Employment in a single position with recurring duties for a short duration, usually for three months or less.

Separated Spouses. Spouses who are granted a judgment of separate support or other related legal relief.

Spouse. Person joined in marriage, as recognized by state law, to an Employee or Retiree.

State Employee, Retiree, Dependent, or Survivor. An Employee, Retiree, Dependent, or Survivor who is eligible for benefits pursuant to M.G.L. c. 32A. Retired Municipal Teachers and Elderly Governmental Retirees are State Retirees. An Employee, Retiree, Dependent, or Survivor who is eligible for benefits only pursuant to M.G.L. c. 32B, § 19 or 23, is not a State Employee, Retiree, Dependent, or Survivor.

Student. Child aged 19 years or older but younger than 26 years of age who attends an accredited educational or vocational institution on a full-time basis.

Surviving Dependent. A deceased insured Employee's or a deceased insured Retiree's Child Dependent, who, younger than 19 years of age, the Child had no surviving parent.

Surviving Spouse. A widow or widower of an insured Employee or Retiree, until death or remarriage. Persons divorced or legally separated from insured Employees or Retirees are not Surviving Spouses.

Survivor. A Surviving Spouse or Surviving Dependent.

Chapter 5.00. Miscellaneous

§ 5.01: Relationship of Department Heads, The Commission and Employees

The Commission has the exclusive responsibility to negotiate all contracts for benefits authorized by M.G.L. c. 32A, M.G.L. c. 32B, §§ 19 and 23, and accompanying regulations. Department heads, including agency heads, reporting location heads, and Group Insurance Coordinators are required to conduct all matters relating to Commission programs described in 805 CMR 5.00 with the Commission unless the Commission's Executive Director gives prior approval.

§ 5.02: Solicitation of Employees

External persons and entities must obtain prior written approval of the Commission's Executive Director to discuss Commission matters with individual employees or groups of employees. If approval is given, group meetings or discussions shall only be conducted at the employees' workplace during duty hours and are subject to the department or agency head's prior approval.

(1) All informational gatherings held for potential Municipal Insureds and Municipal Employers must include representatives of all of the Commission's health plans that serve the area to attend the gatherings to the extent that such meetings are attended by any health plan representatives.

(2) Health Plans, insurance carriers, agents, brokers or representatives are prohibited from advertising to or soliciting any benefit plans or programs to groups for whom the Commission is the exclusive sponsor. Entities with Commission benefits must offer to their employees, retirees, and survivors all such benefits for which their Insureds are eligible, and may not offer competing benefits, except where expressly authorized in statute. After written notice to the Commission, Municipal Employers and Municipal Insureds who are considering withdrawal from Commission Health Coverage may advertise for or solicit such plans or programs in order to procure other health coverage after withdrawal. Any person or entity that the Commission determines has violated the provisions of 805 CMR 5.02 shall be ineligible to bid on Commission business for a period of up to five years.

§ 5.03: Participation of Non-state Funded Employers Other than Municipal Employers

Other than Municipal Employers, non-state funded employers whose employees, retirees, or survivors participate in Commission coverage as expressly mandated by state law shall directly reimburse the Commission for premium payments made on behalf of the employers' Insureds, together with an administrative fee. Reimbursing entities shall pay the Commission no later than 30 days from the date of the Commission's invoice. The Commission may include in its

administrative fee a charge determined by the State Comptroller for late payment. Such late charge shall be billed separately and identified on a subsequent Commission invoice.

§ 5.04: Providers and Benefits

(1) A participating Nurse Practitioner operating within the scope of his or her license, including all regulations requiring collaboration with a physician under M.G.L. c. 112, § 80B, shall be considered qualified as primary care providers for the Commissions' Insureds. Health Plans that fail to comply with the law's provisions will be deemed a prima facie violation of the Consumer Choice of Nurse Practitioner Services Act and a breach of its contract with the Commission, subject to a fine or other such remedies as the Commission determines to be reasonable.

(1A) A participating Physician Assistant operating within the scope of his or her license, including all regulations requiring collaboration with a physician under M.G.L. c. 112, § 9E, shall be considered qualified as primary care providers for the Commissions' Insureds. Any Commission health plan that fails to comply with the provisions of M.G.L. c. 176S will be deemed to have violated the Consumer Choice of Physician Assistant Act and to have breached its contract with the Commission, subject to a fine or other such remedies as the Commission determines to be reasonable.

(2) Health plans that require Insureds to designate a primary care provider shall provide clear and concise information to Insureds that they may select a participating Nurse Practitioner or Physician Assistant as a primary care provider or may change their medical provider to a participating Nurse Practitioner or Physician Assistant. Insureds' Evidence of Coverage shall also contain a clear, concise and complete statement that the carrier will provide benefit coverage to subscribers on a Nondiscriminatory Basis for covered services when delivered or arranged for by a participating Nurse Practitioner or Physician Assistant.

(3) Notwithstanding any general or special law to the contrary, the Commission's health plans shall include and make available to Insureds the same type of information about participating Nurse Practitioners or Physician Assistants as they provide about their participating physicians, and shall display the participating Nurse Practitioner and Physician Assistant information in the same manner and format as they do for their participating physicians.

Chapter 7.00. Retired Municipal Teachers

§7.01: Retired Municipal Teachers: In General

(1) A Local Governmental Unit that accepts M.G.L. c. 32B, § 11E shall inform the Commission in writing of its decision to transfer its retired teachers to the Commission's Health Coverage for Retired Municipal Teachers.

(2) Upon receiving the Local Governmental Unit's acceptance notice, the Commission shall consider applications from the Local Governmental Unit and shall notify the Local Governmental Unit's treasurer that the Commission has approved the coverage transfer. Thereafter, the Local Governmental Unit shall promptly notify all teachers whom it employs that they must be enrolled in the Local Governmental Unit's basic life insurance upon retirement in order to be eligible for the Commission's life insurance and Retired Municipal Teacher health coverage.

(3) Eligible retiring teachers or their surviving spouses, as applicable, who apply when first eligible to be insured in the Retired Municipal Teachers' Program, must complete a Commission application in order to avoid a lapse in coverage. Teachers shall complete and submit their applications to the Commission approximately three months before their anticipated Coverage effective date determined by the Commission.

(4)(a) Retiring teachers whose Local Governmental Unit participates in the Commission's Retired Municipal Teacher program are required to be insured with the Local Governmental Unit upon Retirement in order to be eligible for Commission coverage.

(b) The Local Governmental Unit providing Retired Municipal Teacher coverage shall provide a notice to all newly hired teachers informing them that they must be enrolled in the Local Governmental Unit's life or life and health coverage at retirement in order to be eligible for Retired Municipal Teacher coverage. The Local Governmental Unit shall allow teachers who have a right to retire but defer their retirement to maintain their eligibility by continuing to be insured for Basic Life Insurance or Basic Life and Health Insurance.

(5) Teachers from a Local Governmental Unit that decides to join Health Coverage pursuant to M.G.L. c. 32B, § 19 are considered to be Retired Municipal Teachers only if their retirement date occurs before July 1st of the year in which the teachers' Local Governmental Unit joins Health Coverage.

(6) Retired teachers who decline Retired Municipal Teacher coverage when they are first eligible may later enroll only during annual enrollment or with satisfactory proof of loss of other health coverage. The Local Governmental Unit must certify to the Commission that the Retired

Municipal Teacher was insured at retirement in the Local Governmental Unit's life or life and health coverage.

§ 7.02: Transfer Procedures, Effective Date of Insurance

(1) The Commission shall contact retiring teachers about their applications for Retired Municipal Teacher coverage, and shall determine their effective dates of coverage. The Local Governmental Unit shall continue to be responsible for providing the retiring teachers' premium contributions to their Local Government Unit coverage until such time as their Retired Municipal Teacher coverage becomes effective.

(2) The Local Government Unit must process Retired Municipal Teacher coverage as follows:

(a) The Local Governmental Unit shall continue to collect premium payment from the retired teachers or their surviving spouses, as applicable, until the Commission sends notice that premium payment has been transferred to pension deduction.

(b) The Local Governmental Unit shall furnish Commission applications to all retiring teachers who, at the time of retirement, are enrolled in life insurance coverage or life and health insurance coverage, along with the notice described in 805 CMR 7.01(2), three months prior to their expected retirement date.

(c) The Local Governmental Unit shall continue to collect retiring teachers' premium for two Calendar Months following the month in which the teacher retires. The first day of the third Calendar Month following the month in which a teacher retires, or a date otherwise determined by the Commission, is the retired teacher's coverage effective date, provided that the retiree pays the required monthly premium for coverage. The Commission shall notify the Local Governmental Unit of all retirees' effective dates of Commission coverage.

§7.03: Correction of Incorrect Premium Payment

(1) If a Local Governmental Unit continues to bill a retiring teacher and also receives premium payment after the retiring teacher's effective date of Commission coverage, the Local Governmental Unit shall refund the payment to the retiring teacher upon satisfactory proof of payment.

(2) If a Local Governmental Unit ceases billing a retiring teacher before his or her Retired Municipal Teacher's coverage effective date, creating a premium payment lapse, the Local Governmental Unit shall bill the teacher for past and current premium due until the Commission notifies the Local Governmental Unit to discontinue billing.

(3) If the Commission's premium is not deducted from the retiring teacher's pension or annuity, the Commission shall bill the teacher directly until the premium has been deducted. Failure to pay the required premium on time shall result in termination of coverage.

§ 7.04: Coverage Options

The Commission shall determine the health coverage options available to Retired Municipal Teachers.

§ 7.05: Termination of Retired Municipal Teacher Status

(1) If the Local Governmental Unit subsequently withdraws from Commission coverage, all Retired Municipal Teachers will cease to be eligible for the Commission's Retired Municipal Teacher coverage. The Commission and the Local Governmental Unit shall jointly determine the termination effective date.

(2) Retired Municipal Teachers whose Local Governmental Unit agrees to join the Commission's Health Coverage pursuant to M.G.L. c. 32B, § 19 cease to be Retired Municipal Teachers and, in so doing, their Commission's Basic Life Insurance and Retiree Dental Coverage ends on the date on which the Municipal Employer joins the Commission's Health Coverage.

(3) A Local Governmental Unit that decides to join Health Coverage pursuant to M.G.L. c. 32B, § 19 must continue to contribute its premium share to Retired Municipal Teacher coverage until the date that all of the Local Governmental Unit's insureds begin their Health Coverage.

Chapter 8.00. Municipal Health Coverage

§ 8.01: Transfer Procedures

The Commission shall determine whether a Municipal Employer that has adopted M.G.L. c. 32B, §§ 19 or 23, qualifies for the Commission's Health Coverage. If the Commission approves a Municipal Employer to transfer all of its Insureds whom the Commission determines to be eligible to join the Commission's Health Coverage, it shall do so according to the conditions set forth in M.G.L. c. 32B, §§ 19, 21, and 23.

(1) Notice. Non-unionized cities, town and districts must send a letter from their chief executive officer stating their decision to transfer the Municipal Employer's subscribers to Commission coverage. Unionized Municipal Employers must provide notice as follows:

(a) Section 19 Notice. For the purposes of notice to the Commission of intent to transfer subscribers sufficient to satisfy M.G.L. c. 32B, § 19 (e), Unionized Municipal Employers must provide to the Commission a copy of the signed and executed Public Employee Committee agreement to join the Commission's health coverage and a cover letter from an authorized official of the Municipal Employer confirming the Municipal Employer's intent to join Commission Health Coverage. The notice deadline may be extended up to a maximum of five business days after the statutory deadline for the sole purpose of executing the Public Employee Committee agreements.

(b) Section 23 Notice. For the purposes of notice to the Commission of intent to transfer subscribers sufficient to satisfy M.G.L. c. 32B, § 23 (a), Unionized Municipal Employers must provide to the Commission a copy of the signed and executed Public Employee Committee agreement, or the order of the three-person panel, under M.G.L. c. 32B, § 21, to join the Commission's health coverage, a copy of the proposal underlying the order of the three-person panel, where applicable, and a cover letter from an authorized official of the Municipal Employer that gives notice of a decision to transfer to the Commission. The agreement or the order and supporting proposal shall include the premium contribution details.

(2) A Municipal Employer's transfer agreement or order whose terms alter the Commission's Health Coverage benefit levels from those determined by the Commission or subsidize Municipal Insureds' health coverage are prohibited, with the exception of Municipal Employers funding pre-tax program start-up costs and annual administrative fees, Medicare Part B premium refunds and such other exceptions as are expressly authorized by law. Prohibited alterations include but are not limited to the following:

(a) Alteration of its subscribers' choice of health carriers, health benefits, or out-of-pocket costs;

(b) Offering non-Commission health insurance coverage;

(c) Making contributions to offset Commission health premium or specific health benefits, including compensating the difference between current municipal benefits and Commission benefits, except as expressly authorized by law, including as authorized by M.G.L. c. 32B, §§ 15(b), 24, and 25;

(d) Obligating the Commission's municipal coverage to pay for health claims that were incurred before the Municipal Insureds' Commission coverage became effective.

Such alterations or subsidies are grounds for rejection or termination from Commission coverage after a 90-day termination notice. In the event that the Commission learns of the violation after Commission coverage has begun, termination shall be retroactive to the initial subsidy or alteration.

(3) Scope of Transfer. Upon the Municipal Employer’s coverage effective date and for the duration of its coverage with the Commission, the Municipal Employer shall not provide any non-Commission health coverage to its employees.

(4) Coverage Effective Date. Health Coverage for Municipal Insureds shall begin on the effective date of transfer as determined by the Commission. The Commission's Health Coverage shall consider only health care claims that are incurred after the Commission's effective date of transfer. The Municipal Employer shall be solely responsible for continuing its Municipal Insureds' health coverage until the effective date of transfer to Municipal Coverage, including coverage of any costs or claims incurred but not reported prior to the effective date of transfer.

(5) Enrollment, Choice of Plans. As of the effective date of transfer to the Commission's Health Coverage, the Municipal Employer shall provide the Commission's forms for Health Coverage enrollment to all prospective insureds, including those who currently are not enrolled in the Municipal Employer's health coverage. Municipal Employer Insureds shall be offered all of the health plan choices as are offered to other Insureds who live in the same geographic area.

(6) Data Required with Notice. A Municipal Employer that has given notice as defined in clause (1) of this section of its decision to transfer shall provide the Commission with a completed “Required Municipal Initial Enrollment Data” of its current enrollee population for whom it provides health insurance coverage. These data shall be provided no later than 30 days after the notice deadline for any given enrollment period and be in a format designated by the Commission. The Commission shall provide the file type, file layout, data elements and the Commission's Municipality Software Application upon request of the Municipal Employers. The Commission will publicize initial enrollment data requirements on its website.

(a) Completeness of the aggregated data shall be assessed by use of the Commission's Municipality Software Application and shall be within a five percent error threshold.

(b) The total count of eligible subscribers, including all employees, retirees, and survivors who would be eligible for Commission health insurance whether or not currently enrolled shall be provided by the deadlines as described above.

(c) All Municipal Employers shall provide the Commission with the following contact information:

(i) IT contact and alternate;

(ii) benefits coordinator and alternate;

(iii) fiscal contact and alternate; and

(iv) authorized official and alternate.

Contact information shall include mailing address, phone number and email address.

(d) All Municipal Employers shall provide their benefits coordinator staff with internet access to utilize the Commission's eligibility system (known as the MAGIC system). The Commission shall provide authentication certificates, user IDs and passwords to allow access to the MAGIC system.

(7) The Municipal Employer shall provide, in advance, a draft to the Commission of the initial subscriber communication, which will be subject to the Commission's review. The Commission shall provide a template for this communication. Future communications regarding the Commission shall be cleared by the Commission in advance of their distribution. The Commission shall provide a master premium contribution chart for the Municipal Employer to use in developing a customized rate chart for its own contribution ratios as well as all benefit related materials. The Municipal Employer shall produce customized rate charts for its subscribers and shall provide them to the Commission in an Americans with Disability Act (ADA) accessible format for the Commission's website.

(8) Municipal Employers that do not meet the Commission's required deadlines during the implementation period may, at the Commission's sole discretion, have their coverage effective date delayed until the next scheduled enrollment period.

(9) If a Municipal Employer chooses to transfer to Commission coverage and its retired teachers currently receive insurance through the Commission's Retired Municipal Teachers program under M.G.L. c. 32A, § 12, all said retired teachers shall transfer from the Commission's fully insured Pool 2 to Pool 1 and may re-enroll in Commission benefits for which they are eligible. Retired Municipal Teachers who transfer to the Commission through their respective Municipal Employers may receive through the Commission only those benefits for which they are eligible under c. 32B, §§ 19 or 23, as applicable, and are no longer eligible for Commission life insurance.

(10) Municipal Employers whose teachers have participated in the Commission's Retired Municipal Teacher program immediately prior to transferring to the Commission' Municipal Insureds' Health Coverage must offer their Retired Municipal Teachers basic life insurance upon transfer to Municipal Health Coverage.

§ 8.02: Health Coverage Payments

(1) The Commission shall determine the full cost rates for Health Coverage, to be shared by the Municipal Employer and Municipal Insureds. The full cost rates shall consist of a premium cost and an administrative fee determined by the Commission. The administrative fee shall not exceed 1 percent of the premium cost.

(2) The Municipal Employer shall arrange for all Municipal Insureds' premium contributions to be deducted from their paychecks or retirement allowance one month in advance of coverage.

(3) No later than March 1, the Municipal Employer shall notify the Commission of any change to Municipal Insureds' premium contribution ratios. Changes to contribution ratios shall be effective July 1st.

(4) The Municipal Employer shall transmit monthly to the Commission the full cost of Municipal Insureds' Health Coverage, including the applicable administrative fee. Payment of Municipal Insureds' Health Coverage is due on a date determined by the Commission. The Commission shall invoice the Municipal Employer on a monthly billing cycle for the full cost health insurance premium liability and administrative fee. Invoices will be sent electronically, via secure email, to each Municipal Employer each month; any adjustments will be separately noted on the following month’s invoice.

(a) In the event that a Municipal Employer fails to pay the cost of its Insureds' Health Coverage within 30 days of the premium due date, the Commission shall send an overdue notice to the Municipal Employer. Payments not received after 30 days' delinquency will be subject to interest charges and further action.

(b) The Commission shall notify the Public Employee Committee, the Municipal Employer, and the Executive Office for Administration and Finance of the delinquency and the Commission's intention to cancel coverage if the Municipal Employer fails to pay the full amount in arrears for more than 60 days from the invoice due date.

(c) As to remaining arrearages, the Commission may inform the state treasurer who shall issue a warrant in the manner provided by M.G.L. c. 59, § 20 requiring the Municipal Employer to pay into the treasury, as prescribed by the Commission, the amount of the premium and administrative expenses attributable to the political subdivision, see M.G.L. c. 58, § 20A.

(d) If any amount remains in arrears at the end of a 90-day period, the Commission may begin termination proceedings of the Municipal Employer's health coverage, and the Municipal Employer may be responsible for all claims incurred during the period in which the full premium was not paid.

(5) If a Municipal Employer fails repeatedly or egregiously to notify the Commission within 60 days of a termination or other loss of eligibility due to a change in employment status, the Commission may assess against the Municipal Employer a financial penalty of $100 per ineligible person per month, or the amount by which actual claims for any ineligible person exceeded premiums paid by the Municipal Employer for that person, whichever is greater.

§ 8.03: Eligibility. Conditions of Participation

(1) To be eligible for Health Coverage, persons affiliated with Municipal Employers must be Employees, Retirees, Survivors, or Dependents, as those terms are defined in §1.02.

(2) For the purposes of implementing M.G.L. c. 32B, §§ 19 and 23, the Commission interprets M.G.L. c. 32B, §§ 19(a) and (e) and §23(h) to mean that eligibility for Health Coverage in political subdivisions that have transferred subscribers to the Commission pursuant to §§ 19 or 23 remains subject to M.G.L. c. 32B. However, for those political subdivisions, the Commission is the sole determinant of who is eligible for Health Coverage. The Commission interprets eligibility under M.G.L. c. 32B to be the same as eligibility under M.G.L. c. 32A, except where there is a clear distinction between the two chapters. Therefore:

(a) Consistent with § 9.08 and the definitions of Employee and Retiree in § 1.02, the employees and retirees of a city, town, regional school district, or any other statutorily authorized district shall not be eligible for Commission coverage unless they are members of a Massachusetts public sector retirement system, are receiving a pension from a public retirement system, or are Survivors of Municipal Employees or Retirees (OBRA is not such a public retirement system for this purpose).

(b) Municipal Employees, except elected officials or others as expressly exempted by law, must meet the requirement of a Regular Work Week, as defined in §1.02. For the purposes of M.G.L. c. 32B, §§ 19 and 23, the reference to “20 hours” in M.G.L. c. 32B, § 2, “Employee” means 20 hours out of a regular work week of 40 hours, or 18.75 hours out of a regular work week of 37.5 hours.

(3) The following individuals are Municipal Employees:

(a) Elected officials, without regard to hours worked or to participation in a pension system, are Municipal Employees at local option, consistent with § 9.02 and M.G.L. c. 32B, § 2, “Employee.”

(b) Members of call fire departments or other emergency services, without regard to hours worked, are Municipal Employees at local option, consistent with M.G.L. c. 32B, § 2, "Employee."

(c) Public school employees are deemed to be Employees during the months of July and August following the school year, without regard to hours worked or to method of payment pursuant to M.G.L. c. 71, § 40.

(d) Traffic supervisors, without regard to hours worked, are Municipal Employees at local option, consistent with M.G.L. c. 32B, § 2A.

(e) Reserve, permanent-intermittent, and call firefighters, without regard to hours worked, are Municipal Employees and, upon retirement, Municipal Retirees, at local option, consistent with M.G.L. c. 32B, § 2B.

(4) The Commission shall determine the effective date for all matters pertaining to Municipal Insureds' Health Coverage, including but not limited to their eligibility, effective dates of coverage, termination, and status changes. The Commission determines whether persons are eligible for Commission coverage as Municipal Insureds according to M.G.L. c. 32A and 32B, and its eligibility decisions are final and binding. Prior coverage through a Municipal Employer does not guarantee Commission coverage.

(5) Municipal Employers that do not meet the Commission's required deadlines during the implementation period may, at the Commission's sole discretion, have their coverage effective date pended until such time as the Commission can determine an appropriate date.

(6) The Municipal Employer shall submit all eligibility and enrollment information requested by the Commission, including census data in a format specified by the Commission, along with documentation that the Commission deems necessary to determine eligibility.

(7) A Municipal Employer's authorized individual shall certify the accuracy of the eligibility information and shall submit the certification, signed under the pains and penalties of perjury, with the eligibility data for the Commission's review and decision. No persons shall be enrolled in Commission coverage without the prior approval of the Commission.

(8) Surviving Spouses of Municipal Employees and Municipal Retirees are eligible for Commission coverage, subject to the provisions of 805 CMR 9.09. Health Coverage for Municipal Employees' and Retirees' surviving spouses ends upon the surviving spouse's remarriage.

(9) Municipal Insureds and their eligible dependents shall be eligible for Health Coverage and shall be subject to the same Health Coverage terms, conditions, carriers, schedules, benefits and benefit levels as those provided to State Employees, Retirees, Survivors, and their Dependents in the pool.

(10) The Commission may audit Municipal Employers for compliance with the Commission's policies and procedures for maintaining Municipal Insureds' Health Coverage.

(11) If they are eligible for Medicare Part A for free, Municipal Retirees, their covered spouses, and Municipal Surviving Spouses are required to enroll in Medicare Parts A and B in order to receive health coverage through the Commission. They must enroll during Medicare's next annual enrollment period. Municipal Employers shall be required to notify all retirees of this obligation and of the next Medicare open enrollment period. The Municipal Employer shall pay any new late entry penalties for its Medicare-eligible Insureds who were required to join Medicare as a condition of transfer to Health Coverage. The Commission shall not pay for or reimburse any Part B premium. Municipal Employers shall reimburse retirees for penalties incurred by their Medicare eligible insureds who are required to join Medicare upon transferring to Commission coverage. A Municipal Employer is not required to reimburse retirees for late enrollment penalties if the retiree did not enroll in Medicare when required.

(12) Upon the Municipal Insureds' Coverage effective date and for the duration of their Health Coverage, the Insureds shall not receive health coverage pursuant to M.G.L. c. 150E, M.G.L. c. 32B or any other arrangement with the Municipal Employer.

(13) The Municipal Employer shall perform all administrative functions and shall process and provide all information that the Commission deems is necessary to administer its Insureds' Health Coverage, including monthly billing reconciliation.

(a) The Municipal Employer and its Insureds, as the case may be, shall furnish all information necessary to maintain its Insureds' Health Coverage in such form, content and frequency as the Commission determines, including but not limited to monthly reconciliation of the Commission's monthly billing file.

(b) The Municipal Employer shall gather eligibility information for enrollment and status changes, and forward a copy of all such documentation to the Commission with each application. Any necessary translation shall be at the applicant's or Municipal Employer's expense.

(14) Municipal Insureds who terminate employment while in good premium payment standing and begin employment with benefits with the same or another Employer before Commission coverage under the prior Municipal Employer ends, shall continue to be insured without a break in existing coverage and must remain in the health plan they enrolled in with the first Municipal Employer, consistent with § 9.19(1). Such Municipal Insureds who begin employment with benefits with the same or another Employer after Commission coverage under their prior Municipal Employer has ended shall be subject to § 9.19(2).

(15) The Commission is not subject to the provisions of M.G.L. c. 30A.

(16) Prior to the effective date of transfer to the Commission's health coverage, the Municipal Employer shall distribute enrollment materials, as provided by the Commission, for health coverage enrollment to all prospective Insureds, including those who currently are not enrolled in the said Municipal Employer's health coverage. The Municipal Employer's Insureds shall be offered the same health plan choices offered to state Insureds who reside in the same geographic area.

(17) Coverage ends on the last day of the calendar month following the month that an employee leaves the service of his or her original Municipal Employer. Premiums shall be collected for that last month by the Municipal Employer.

(18) If a former Spouse is eligible under the terms of a divorce decree and enrolled under the insured's family plan, coverage for the former Spouse under the insured's family plan will end upon the remarriage of either the Insured or Spouse. The former Spouse may be eligible for a divorced Spouse rider or COBRA coverage as determined by the Commission depending upon the language in the divorce decree.

§ 8.04: Coverage Continuation and Termination, Notice Deadline

(1) A Municipal Employer that transfers to Health Coverage due to a Fiscal Emergency declared by the Legislature may continue Health Coverage for its insureds after the governing finance control board or receiver determines that a Fiscal Emergency no longer exists or otherwise ends its oversight of the Municipal Employer. If a Municipal Employer remains in Health Coverage after release from finance control board oversight, the Municipal Insureds' Health Coverage shall be subject to the same Commission rules and regulations that apply to Municipal Employers whose Insureds have joined Health Coverage pursuant to M.G.L. c. 32B, § 19.

(2) If a Municipal Employer terminates Commission coverage without giving notice by the deadline, the Municipal Insureds' Health Coverage shall be cancelled for nonpayment retroactive to the last month for which the Municipal Employer paid its share of the premium.

(3) A Municipal Employer transferring out of the Commission's coverage pursuant to M.G.L. c. 32B, §§ 19 or 23 shall provide the Commission with notice on or before October 1 for transfer on July 1 of the following year. The effective date for a Municipal Employer to withdraw from Commission coverage shall be on July 1 of the expiration year as specified in a municipal entity's bargained agreement or Order of the Panel, and Commission coverage shall end on June 30.

(4) A Municipal Employer that withdraws from Commission coverage and does not immediately transfer its Insureds to the Commission pursuant to a different section of c. 32B may not transfer its Insureds to the Commission for three years. For example, a Municipal Employer may

withdraw from Commission coverage pursuant to M.G.L. c. 32B, § 19 effective July 1 and transfer its Insureds to Commission coverage pursuant to M.G.L. c. 32B, § 23, as of the same July 1. However, if it does not do so, but instead withdraws from all Commission coverage, it may transfer its Insureds once again to the Commission no earlier than July 1, three years after the effective date of the earlier withdrawal.

§ 8.05 – Reserved

§ 8.06 Data Management and Communication

(1) Municipal Employers shall report all changes to an enrollee's coverage on forms designated by the Commission. Upon notification from the Commission, Municipal Employers shall be required to enter on the Commission's eligibility system (MAGIC system), an enrollee's coverage and/or coverage changes.

(2) The Commission determines the effective date of enrollees' coverage changes including, but not limited to: individual to family, family to individual, and cancellation of coverage and shall notify the Municipal Employer directly via the Premium Deduction Change Notice. The Municipal Employer shall accept this notice and update its records accordingly.

(3) Municipal Employers shall reconcile their entire insured membership on a monthly basis via the Statement of Verification that is included with the monthly bill and roster. Municipal Employers shall report any discrepancies to the Commission at a time determined by the Commission. Late notification of discrepancies to the Commission may result in a delay in the effective date of insurance coverage changes.

(4) Any Municipal Employer that transfers its insureds to the Commission with more than one enrollee percentage contribution towards a particular individual, family or Medicare health plan premium shall provide the Commission with enrollment data by enrollee percentage contribution for said health plan(s). Reporting shall be monthly, or less frequently as required by the Commission, on a form that will be provided by the Commission.

(5) A participating Municipal Employer or its Public Employee Committee may request data for the sole purpose of determining whether it will continue to participate after three years, as specified in its executed Public Employee Committee agreement or order from the three person arbitration panel. Requests for such data shall be made in the preceding or current fiscal year in which a given agreement is open to negotiation, and such requests shall be limited to one request in the preceding or current fiscal year in which a political subdivision is considering withdrawing from coverage.

(a) Entities requesting utilization data should assess the amount of time they will need to analyze data and conduct negotiations before making a decision about whether to remain in the Commission. Such entities must submit their requests to the Commission at least 45 days before the data are to be provided to them to use in their decision-making process. In a City, the request must be signed by the City Manager or the Mayor, in a Town by the Chairman of the Board of Selectmen, and in a regional school district, by the Chairman of the Regional School District Committee. For a Public Employee Committee, the request must be signed by a majority of the representatives of the Public Employee Committee, or by a weighted majority of representatives by membership in the Public Employee Committee. The Commission will notify the relevant Municipal Employer of a data request from a Public Employee Committee.

(b) The Commission will provide the following data to each requesting entity with more than 50 subscribers:

(i) A monthly claims report consisting of the following data elements:

a. the subscriber count;

b. the covered lives count;

c. the total paid medical claims;

d. the total paid prescription drug claims.

(ii) A yearly large loss report, i.e., for claimants who have incurred $25,000 or more paid claims in a given year consisting of the following elements:

a. the de-identified claimant ICD-9 or ICD-10 codes (diagnoses);

b. the de-identified claimant total paid claims (medical and prescription drug).

The Commission will provide Protected Health Information to requesting entities as the Commission's Business Associates subject to the HIPAA Privacy Rule after each signs the Commission's Business Associate Agreement (BAA). In the event that a Municipal Employer or a Public Employee Committee both request data in the same year, the Commission will supply data for the same time period to both entities.

Municipal Employers and Public Employee Committees that have requested these data will be required to designate a single person to handle these data, and such persons will be required to sign a BAA in which they agree not to share these data with other parties. Before receiving these data, the requesting entity agree to execute a BAA with the Commission in which they agree that only their single designated person shall handle these data, and that these data shall not be shared with anyone other than insurance brokers, benefits consultants, and health plans for the limited purpose of securing bids for the procurement of health insurance.

Requesting entities wanting Medicare HMO data or fully insured retiree dental coverage data should use the monthly premium as a substitute for actual cost. Administrative costs are not included in the data provided.

(6) On or before January 15, 2013 or any later year, at the request of a Municipal Employer, the Commission will make available to the Municipal Employer a list of that Municipal Employer's current members. A Municipal Employer must make any such request by November 15th of the prior year. The purpose of this list is to assist the Municipal Employer in meeting its obligations under M.G.L. c. 32B, § 26.

§ 8.07 Commonwealth Charter Schools, Education Collaboratives, Regional Planning Agencies, and Regional Councils of Government

(1) Eligibility. Employees, Retirees, Survivors, and Dependents of Commonwealth charter schools, education collaboratives, regional planning agencies, or regional councils of government are eligible for Commission benefits if they are statutorily entitled to such benefits pursuant to M.G.L. c. 32A, § 2(b), or if the Commonwealth charter school, education collaboratives, regional planning agencies, or regional councils of government has adopted M.G.L. c. 32A as specified in M.G.L. c. 32A, § 2(b), M.G.L. c. 32A, § 3B, or M.G.L. c. 32B, § 21(a), whichever is applicable.

(2) Notice. Non-unionized Commonwealth charter schools must provide a certified copy of the majority vote of their board of trustees to join Commission health coverage; non-unionized Education Collaboratives must provide a certified copy of their boards of directors' majority vote to join Commission coverage. Regional planning agencies and regional councils of government must provide a letter from their governing board stating their decision to join Commission coverage. Unionized Commonwealth charter schools and unionized educational collaboratives must provide the Commission with notice of intent to transfer as required by M.G.L. c. 32B, § 19 or § 23.

(3) Commonwealth charter schools, education collaboratives, regional planning agencies, or regional councils of government shall follow the transfer protocols in 805 CMR 8.01.

(4) Terms. Except as otherwise stated in this section, Commonwealth charter schools, education collaboratives, regional planning agencies, or regional councils of government who opt to join Commission coverage are subject to applicable requirements of M.G.L. c. 32A and related regulations.

Chapter 9.00. Eligibility and Participation

§ 9.01: New Employees

(1) A new Employee's department or agency head shall determine within the first ten days of employment whether the Employee is eligible for Commission coverage. Employees whose duties are Seasonal or Emergency Employment or of a duration of not more than three months with no reasonable expectation of an extension, are not eligible for Commission coverage. Department or agency heads who are unable to determine eligibility shall send all information relating to the new Employee's work to the Commission for a final and binding eligibility determination. Persons who do not enroll in Commission coverage when they are first eligible may later enroll during the Commission's Annual Enrollment or upon satisfactory proof of loss of other coverage. Once an Employee enrolls in a health plan, the next opportunity to change plans is the GIC's next Annual Enrollment period, except as otherwise required by law.

(2) Members of the Judiciary who qualify as Employees are eligible for Commission coverage.

(3) Effective Date of Insurance Coverage. Eligible Employees who apply for coverage within ten days of the first day of employment shall be insured on the first day of the month following the earlier of 60 calendar days or two calendar months from the first day of employment. The first day of employment shall be counted when determining the effective date of Commission coverage, and one or more days of authorized leave of absence shall be counted as an equivalent number of days of employment.

(4) Retroactive Health Insurance Effective Date. Employees or dependents may request Commission Health Coverage to begin on the first day of employment or the first day of the health coverage waiting period referenced in 805 CMR 9.01(3), as applicable, if all of the following conditions are met:

(a) the Employee or Dependent is not enrolled in other health coverage and incurs an unplanned and urgent medical expense that exceeds the Employee's full cost monthly premium;

(b) the unplanned and urgent medical expense occurs on or after the first day of employment or waiting period but before the effective date of health coverage;

(c) the Employee requests such coverage in writing and provides satisfactory documentation of the unplanned and urgent medical expense.

Coverage shall become effective as of State Employees' first day of active employment or Municipal Employees' first day of the waiting period, subject to their timely payment of the full-cost health insurance premium for the entire hiatus period. New Employees who begin employment on the 16th day of a month or later will not be charged premium for that month;

new Employees who begin employment on or before the 15th day of a month shall be charged the full premium cost for the month. Coverage entitles the Employee only to those benefits that are otherwise available through the health plan selected, and claims may be denied in whole or in part, consistent with the health plan's covered benefits.

Employees' effective date of life insurance shall only become effective as described in 805 CMR 9.01(3) or 805 CMR 9.02.

(5) Employer Notification to New Employee. The Employee's department or agency head or Group Insurance Coordinator shall inform newly hired employees whether they are eligible for Commission coverage and what benefits are available to them, including Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage. The Group Insurance Coordinator shall also notify newly hired employees that premium deductions for Commission coverage are taken one month in advance of coverage.

(6) New Employees' Duty to Notify Employer. Eligible Employees who are advised by their department or agency head that they are eligible for Commission coverage shall, within ten days of beginning work or beginning the health care waiting period, inform their employer whether they intend to enroll in Commission coverage. Those enrolling in Commission coverage shall promptly select coverage and complete all necessary forms. Persons who fail to enroll in Commission coverage when first eligible may do so during the next occurring Annual Enrollment period or with satisfactory proof of loss of other coverage.

(7) Premium payment for Commission coverage must be made one month in advance of coverage in order for coverage to become effective.

(8) As a condition of employment, employees shall provide information to the Commonwealth as required by law, including but not limited to disclosures required by the Health Care Reform Act.

(9) If an employee is requesting a coverage effective date change to a different month, the employee's effective date of coverage shall be determined by the Commission, and is subject to receipt of premium before coverage becomes effective.

(10) Recalled Employees who do not continue their coverage with the Commission during the period when they are laid off shall be treated as re-employed persons, consistent with § 9.19.

§ 9.02: Elected Officials

(1) Officials elected by popular vote are eligible for coverage on the first day of the month nearest the date that they begin their term of office, excepted as noted in clause (2). Appointed employees and officials are subject to the waiting period for coverage in 805 CMR 9.01(3).

(2) Elected officials who are Municipal Employees and who have a Regular Work Week of less than 18.75 hours are eligible for coverage only at local option, per M.G.L. c. 32B, § 2 (d), "Employee." Municipal Employers shall inform the Commission by May 1 of each year of any change in eligibility of elected officials. Notification of the local option is binding on the Municipal Employer for the fiscal year starting that July 1.

§ 9.03: Eligibility for Health Coverage

(1) Municipal Insureds, Survivors, and Elderly Governmental Retirees are eligible to enroll in Health Coverage without electing any other benefit. All other Employees and Retirees, including Retired Municipal Teachers must be enrolled in Basic Life Insurance in order to be eligible for Health Coverage.

(2) Persons who cancel their Medicare coverage will next be eligible for the Commission's Health Coverage on July 1st after they reapply for Medicare and are reinstated to Medicare coverage. Commonwealth Retirees shall be solely responsible for any Medicare penalties incurred by the cancellation.

(3) During any of the Commission's Annual Enrollment periods, uninsured Employees, Retirees and Survivors may elect Commission health coverage, which shall become effective the next occurring July 1st.

(4) Employees, Retirees, Survivors, and Dependents may enroll in Commission health coverage if they provide acceptable proof of loss of other coverage and are otherwise eligible for the coverage. The Commission shall determine the effective date of coverage.

(5) Employees, Retirees, and Survivors who terminate coverage due to non-payment of premiums may re-apply during any of the Commission's Annual Enrollment periods provided they are otherwise eligible for coverage.

§ 9.04: Individual and Family Health Coverage

(1) Employees who elect Individual Health Coverage at the time of hire may later elect Family Health Coverage due to a change in family status (e.g., marriage or adoption, spouse's loss of other coverage), subject to verifying documentation acceptable to the Commission including, but not limited to, marriage and birth certificates. Verification that requires translation shall be at the applicant's expense. The effective date of the family status change is determined by the Commission.

(2) Employees, Retirees, and Surviving Spouses whose dependents cease to be eligible for Commission coverage must notify the Commission within 30 days of such occurrence. The Commission shall determine the effective date of dependents' coverage termination.

(3) Employees, Retirees or Surviving Spouses may change their Family Coverage to Individual Coverage only by providing proof of their Dependents' other coverage or a change in family circumstance as described in 805 CMR 9.04. The Commission's decisions relating to coverage termination requests are final and binding.

(4) If a death changes a State Employee, State Retiree, or State Survivor's coverage status from Family to Individual coverage, the Commission may refund up to two years of premium overpayment, if any, after the death is reported to the Commission.

(5) Where a Retiree or Surviving Spouse is enrolled in a Commission Medicare plan, any non-Medicare-eligible Dependent may enroll only in Health Coverage with the same carrier as the Retiree or Surviving Spouse, and all such Dependents must enroll in the same plan. Likewise, where a Retiree or Surviving Spouse is enrolled in a non-Medicare plan, any Medicare-eligible Dependent may enroll only in a Commission Medicare plan with the same carrier as the Retiree or Surviving Spouse, and all such Medicare-eligible Dependents must enroll in the same Medicare plan. Any Medicare-eligible Dependent of a Retiree or Survivor in a Commission Medicare plan must enroll in the same Commission Medicare plan as the Retiree or Survivor.

(6) Divorced spouses of Employees or Retirees cannot be terminated from Commission health coverage for reasons of additional cost when their children are no longer enrolled in the coverage unless the divorced Employee or Retiree has remarried or the divorce agreement expressly defines such a scenario as constituting additional cost.

(7) For an Employee, Retiree, or Surviving Spouse with Family Health Coverage to enroll in a plan with a defined geographical enrollment area, all enrolled family members, including all covered Dependents, must reside in the plan's service area. For the purposes of this clause, Children younger than 19 years of age and Students are deemed to reside with the Employee, Retiree, or Surviving Spouse on whose plan they are Dependents, unless that Employee, Retiree, or Surviving Spouse is not the Child's or Student's custodial parent. In that case, Children younger than 19 years of age and Students are deemed to reside with their custodial parent. In the event that an enrolled family member no longer resides in the plan's service area, the Employee, Retiree, or Surviving Spouse must either:

a) disenroll the Dependent who no longer resides in the plan's service area, subject to other applicable requirements as outlined in this section; or

b) enroll in a plan with an appropriate service area, or with no geographical restrictions.

If the latter course is elected, the Employee, Retiree, or Surviving Spouse must change plans concurrently with the change in residence, outside of the Annual Enrollment period if necessary.

§ 9.05: Duplicate Coverage Prohibited

(1) In the event that a person is eligible for Commission benefits as an Employee or Retiree of more than one Employer, or as more than one of the following categories: Employee, Retiree, and Dependent; the person must elect a single such status for the purposes of enrolling in Commission benefits. For example, a person who qualifies both as a State Retiree and as a Municipal Employee may elect to be treated as either one, but not both.

(2) If both members of a married couple are Employees or Retirees and both are enrolled in Commission coverage, they may either:

(a) each have Individual Health Coverage; or

(b) have Family Health Coverage covering both spouses and all other eligible Dependents.

If a couple elects Family Health Coverage, only one spouse of the couple may be the named Insured for the Family Coverage. Both Employee spouses may each enroll in Basic Life Insurance coverage.

(3) If both members of a divorced couple are Employees or Retirees and both are enrolled in Commission coverage, they may have Family Health Coverage covering both former spouses and all other eligible Dependents. Alternatively, each may independently elect Individual or Family Health Coverage. In that case, a Dependent may not be covered on more than one plan.

§ 9.06: Leaves of Absence

(1) Employees may continue their Commission coverage while on an authorized leave of absence without pay for reasons other than personal illness or injury. Such Employees are responsible for the entire premium cost; no Employer contribution shall be made, except as otherwise provided in 805 CMR 9.06.

(2) Employees on leave of absence without pay for six or more continuous months will only be eligible for coverage if the Commission approves. Such Employees must pay the entire premium and must apply to renew their application with the Commission every six months.

(3) Employees who are absent from work due to personal illness or injury, for which they are receiving Worker's Compensation benefits pursuant to M.G.L. c. 152 or any similar law or regulation, and whose salary ceases due to lack of sick leave credits, must be given written notice

from the Employer and an accompanying application that they may be eligible to continue their coverage by paying the employee's share of the premium cost. The Commission shall make a determination as to applicants' eligibility when it receives their completed applications. Employees approved for coverage shall recertify their continued eligibility for coverage with the Commission at six month intervals.

(4) Employees who are not entitled to receive salary or wages while awaiting a determination of eligibility for Worker's Compensation benefits shall be deemed to have been granted a leave of absence without pay, and may continue their existing coverage by paying the entire monthly premium cost with no contribution made by the Employer. Employees approved for Worker's Compensation may apply for a reduction of premium, which the Commission will review and may refund the amount for which the employer is properly responsible.

(5) Entitlement to Worker's Compensation benefits does not entitle a terminated Employee to continue Commission life or health coverage.

(6) Employees on a leave of absence for one year who pay the Employee's share of premium may thereafter continue to receive their Health Coverage if they continue to pay the Employee's share of the premium cost and the Employee's agency pays the Commonwealth's share of the premium cost.

(7) Employees on a medical leave of absence (excluding worker's compensation, industrial accident or maternity leave) may continue to receive their Health Coverage by paying the Employees' share of the premium cost only after they have exhausted their accrued sick and vacation time.

(8) Employed and Re-employed Members of the Uniformed Services are subject to the requirements of the Uniformed Services Employment and Re-employment Rights Act (USERRA).

(a) Employed and re-employed members of the uniformed services who are absent from employment by reason of service may elect to continue their Commission coverage up to the lesser of either 24 months from the date their absence begins or the day after the date on which they fail to apply for or return to their employment positions. Members who elect to continue their Commission coverage are required to pay the full premium cost; however, members who perform service for fewer than 31 days are not required to pay more than the Employee's share, if any, for such coverage.

(b) Members who do not elect to continue Commission coverage or do not pay for it in a timely manner may, upon the members' departure for service, have their coverage terminated unless their failure to elect was excused because continued payment was impossible, unreasonable or precluded by military necessity. The Commission shall reinstate such members' health coverage retroactively if they elect to continue coverage and pay all unpaid amounts due.

(c) Re-employed members, except in the case of those who elect continuing coverage, will not have a waiting period if such a waiting period would not have been imposed for reasons other than uniformed service.

(9) Employees who are absent from work for 30 days or more are considered to be on leave of absence for the purpose of Commission coverage.

§ 9.07: Subsequent Determination of Ineligibility

If premiums have been paid and accepted on behalf of a person enrolled in Commission coverage and the Commission later determines that the person was not eligible, Commission coverage shall cease as of the end of the period for which the Commission last received premium payment. The ineligible person shall not be entitled to continuation coverage except as required by federal law.

If an employee initially is eligible and insured under the Commission's programs but thereafter becomes ineligible due to a change in employment or status in the service of the Commonwealth or of one of its participating municipalities, his or her Commission coverage shall terminate at the end of the month following the month in which the change that caused the Employee's ineligibility occurs or a later date as determined by the Commission. Such employees shall be entitled to Continuation Coverage, unless the ineligibility is due to termination for gross misconduct.

§ 9.08: Employees not Entitled to Receive a Pension or Retirement Allowance

Except for Elected Officials, Employees who are not entitled to receive a pension or a retirement allowance when they terminate employment or who subsequently lose or withdraw their pension after retirement are not eligible to continue Commission Coverage. However, Employees other than Municipal Employees may be entitled to Commission life insurance portability or conversion and health insurance Continuation Coverage as set forth in §§ 9.13 and 9.14; Municipal Employees and their Dependents may be eligible for health insurance Continuation Coverage as set forth in §§ 9.13 and 9.14.

§ 9.09: Surviving Spouses

Surviving Spouses may elect to remain insured only for Health coverage until their remarriage or death. They must apply for Surviving Spouse coverage within six months of the Employee's or Retiree's death. Additional time to apply may be granted for delays due to the applicant's medical condition or the existence of other coverage that has since terminated.

(1) Surviving Spouses of deceased Employees or Retirees who were enrolled in Commission Coverage at the time of the Insureds' death may elect only Health Coverage until their remarriage or death. Surviving Spouses must apply for Surviving Spouse Health Coverage.

(2) Surviving Spouses who are eligible for coverage as Employees are not eligible for survivor coverage unless they terminate employment. Enrollees who are eligible for coverage as Retirees are not eligible for survivor coverage.

(3) Divorced or legally Separated Spouses are not Surviving Spouses and are not eligible for Surviving Spouse coverage.

(4) Surviving Spouses who receive a retirement allowance must have their Health Coverage premium deducted from their retirement allowance.

(5) Widows and widowers of deceased Insureds are only eligible for Surviving Spouse coverage if the deceased was enrolled in Commission coverage at the time of death.

§ 9.10: Surviving Dependents

Surviving Dependents may elect Health Coverage until the Surviving Dependent becomes eligible to enroll in other group health coverage or becomes 26 years of age, whichever occurs first. Surviving Dependents must apply for Health Coverage within six months of the employee's or Retiree's death. For good cause shown, the Commission may grant additional time to apply.

§ 9.13: Conversion of Health Coverage: Continuation Coverage Options

(1) Insured Employees in good premium standing who terminate their employment and whose Dependents become ineligible for Commission Health Coverage may convert their Health Coverage to non-group conversion or continuation Health Coverage, including Federal "COBRA" coverage, and Massachusetts Health Connector Authority coverage, provided that they apply for health coverage 31 days following the later of:

(a) termination of Family Health Coverage; or

(b) the date that the former health plan or the Commission notifies the former Employee of his or her right to obtain non-group coverage, provided that the Employee is in good premium payment standing on the date of his or her group Health Coverage termination.

(2) Surviving Spouses or Surviving Dependents who are no longer eligible for Health Coverage and who decline Health Coverage as survivors may enroll in a non-group plan of health

coverage, provided that they make timely application to the health plan. The effective date of non-group health coverage shall be determined by the health plan.

(3) Insured Employees, Retirees, or Surviving Spouses or Dependents who remain eligible for Commission coverage but who voluntarily withdraw from or decline to enroll in Commission coverage, or are terminated for nonpayment of premium, are not eligible for non-group conversion coverage.

§ 9.14: Conversion of Life Insurance: Continuation Coverage Options

Insured Employees who leave employment or become ineligible for Commission coverage due to a reduction in hours may either apply for portable group term life insurance similar to their Commission life insurance or may convert their life insurance to a non-group life insurance plan with the carrier providing Commission life insurance coverage when the Commission coverage ends without having to provide medical evidence of insurability. Employees must apply to the group life insurance carrier for portable life insurance coverage within 31 days of terminating Commission coverage and pay the first month's premium within 31 days of the date of the carrier's premium bill or within 15 days of the date the notice of conversion right is sent to the employee. Employees applying for non-group conversion coverage must do so within 90 days of the Commission's coverage termination. Only applicants in good premium standing when terminating their employment can be considered for continued coverage.

§ 9.15: Misstatement of Information and Misuse of Benefit Plans

(1) An Insured's coverage may be terminated, in addition to other civil or criminal penalties, if the Commission determines that the Insured provided incorrect information in submitting a medical evidence of insurability or other such form that resulted in approval of the Insured's coverage request. The Commission shall establish the extent and duration of the termination.

(2) Any Insured who procures services fraudulently or submits false claims for himself or herself, or otherwise enables a person who is not eligible for Commission coverage to fraudulently enroll, procure services for, or submit claims for Commission coverage shall, upon determination by the Commission and in addition to other civil or criminal penalties that may be imposed, forfeit his or her eligibility for Commission coverage. The Commission shall establish the extent and duration of the forfeiture.

(3) Personal reimbursement of out-of-country health care claims will only be provided to Insureds who produce all related records requested by the plan and, as necessary, their translation; an itemized bill for health care claimed and, as necessary, its translation; and satisfactory proof of personal payment of the claims by cancelled check or credit card statement.

Reimbursement is subject to the reasonable and customary payment as determined by the health plan, based on the locality where services were rendered.

§ 9.16: Retired National Guard Technicians

(1) National Guard Technicians retired after January 1, 1969 who receive a pension from the State Retirement System may become insured as Retirees, notwithstanding the period of time from January 1, 1969 to their retirement when they were Federal employees, provided that they were insured on the date of transfer from the state employment to federal employment.

(a) Such National Guard Technicians must complete an application for Commission coverage.

(b) The application for coverage must be received by the Commission within 31 days following the date of retirement. Persons who fail to submit a timely application may reapply at the Commission's next occurring Annual Enrollment.

(2) National Guard Technicians retired after January 1, 1969 who receive a pension from the State Retirement System but who have never been insured through the Commission may be insured as Retirees only after compliance with the retirement pre-conditions described in 805 CMR 9.16.

(3) National Guard Technicians who have no right to receive a pension from the State Retirement System are not eligible to be insured as Retirees.

§ 9.17: Surviving Spouses of National Guard Technicians

(1) Surviving spouses of insured Retired National Guard Technicians may be insured for health insurance only.

(2) Surviving spouses of Retired National Guard Technicians who were federal employees at the time of death may be insured for health insurance only, provided that such National Guard Technicians were insured by the Commission on the date of their transfer from state employment to federal employment.

§ 9.18: Retired Employees' Return to Active Employment

Retirees who subsequently are hired for a position with benefits by the Commonwealth or a Municipal Employer may either continue their Commission coverage as active employees if they waive their monthly retirement allowance, or may continue to have their retiree premium deducted from their retirement allowance.

§ 9.19: Re-employed Persons

(1) Insured Employees who terminate employment while in good premium payment standing, who are re-hired as Employees in a position with benefits and begin employment before Commission coverage ends under their prior public employment, shall continue to be insured without a break in existing coverage, provided that they submit a timely application for Commission coverage.

(2) Insured Employees who terminate employment while in good premium payment standing and are re-hired as Employees after their Commission coverage ends shall be insured as new Employees and will be subject to the New Employee waiting period for Commission coverage.

(3) Notwithstanding clause (2) of this section, Insured State Employees who terminate employment while in good premium payment standing and are re-hired as State Employees in a position with benefits within two years of the date of termination of their employment shall be considered to have been hired on their original hire date for the purposes of computing the Commonwealth's share of their premiums.

(4) In the event that an Insured State Employee is reinstated in a prior position as the outcome of a labor arbitration, a Massachusetts Commission Against Discrimination (MCAD) proceeding, or court order, such employee shall be considered to have been hired on his or her original hire date for the purposes of computing the Commonwealth's share of premiums. Benefits as an active State Employee will be reinstated prospectively as soon as is administratively feasible, without waiting for the next Annual Enrollment period.

§ 9.20: Retirement - General

(1) Retirees entitled to a pension or retirement allowance may continue Basic Life and Health Insurance coverage, and Additional Life Insurance by applying to continue the coverage and continue paying the required premium. State Retirees, Retired Municipal Teachers, and eligible Municipal Retirees may also enroll in the Commission's retiree dental coverage by submitting an enrollment application in a timeframe as determined by the Commission.

(2) State Retirees who never have been insured through the Commission and initially apply for Commission coverage as State Retirees are eligible to apply for the Commission's Retiree Basic Life, Health Coverage and Retiree Dental coverage.

(3) Retirees who are re-hired as employees under the applicable provisions of M.G.L. c. 32 and are receiving adjusted salary or wages are not eligible to be insured as active employees. Retirees who waive and renounce their rights to all pension or retirement allowance payable to them for a

period of time in accordance with M.G.L. c. 32, and are not rehired as full-time employees for a period of time that does not constitute Emergency Employment, may be insured as Employees subject to payment of the Employee's share of the premium.

(4) Eligible Retirees who voluntarily withdraw from Basic Life or Basic Life and Health Coverage may apply to re-enroll in Commission coverage either during the next Annual Enrollment or if they provide acceptable proof of loss of other coverage.

(5) Deferred retirees are considered to be employees on leaves of absence without pay for as long as they retain the right to receive a retirement allowance from a participating retirement system and do not withdraw their pension monies from the retirement system. Persons receiving a retirement allowance cease to be Deferred Retirees.

(6) Once a Retiree enrolls in a health plan, the next opportunity to change plans is the GIC's next Annual Enrollment period, except as otherwise required by law.

§ 9.21: Additional Life Insurance

(1) All eligible Employees enrolled in Basic Life Insurance may apply for Additional Life Insurance consisting of group term life insurance and accidental death and dismemberment insurance. New Employees who enroll when first eligible are eligible for Additional Life Insurance in an amount up to eight times their salary without providing medical evidence of insurability.

(2) Evidence of insurability shall be required when an Employee:

(a) applies for initial coverage after the deadline for applying has passed, unless certain life events occur that qualify under the policy for coverage without providing such evidence; or

(b) seeks to increase the amount of his or her Additional Life Insurance; or

(c) seeks to be reinstated after losing coverage for failing to pay the required premium.

(3) If a physical examination is required to determine eligibility for Additional Life Insurance, the life insurance carrier shall review the medical evidence and determine eligibility for the additional coverage based upon its underwriting standards. Such standards shall be consistent with the life insurance underwriting standards in general use by the insurance industry. In addition, the life insurance carrier's underwriting criteria shall not consider the applicant's age, gender, occupation or amount of life insurance requested. Consideration shall be given only to the applicant's medical evidence of insurability, recognizing the size of the group and volume of insurance administered by the Commission in determining standards of acceptability and insurance risk.

(4) Upon retirement, Retirees may continue or reduce the amount of their Additional Life Insurance in effect at that time, upon full and timely premium payment. Retirees who cancel or reduce their Additional Life Insurance are eligible to continue their coverage directly with the carrier. Persons who have not previously had Additional Life Insurance are not eligible for the coverage upon or after retirement.

(5) Pensioned justices who are recalled to judicial duties on full-time assignment are eligible for Additional Life insurance without providing medical evidence of insurability if they waive their pension for the duration of the full time recall period.

(6) The effective date of an Employee's life insurance beneficiary designation is the date that the Commission receives the completed beneficiary designation form.

(7) Employees who are enrolled in Basic Life Insurance but do not enroll in Additional (Optional) Life Insurance when first hired may later elect the coverage due to a change in family status without having to provide proof of good health. Applicants must apply for the Additional Life Insurance and provide evidence of the family status change within 31 days of the event causing the status change.

§ 9.22: Dental and Vision Benefits

The Commission and the vendor(s) providing Dental and Vision benefits shall determine the conditions for participation, the amount of benefits and their duration, premium rates and all effective dates of coverage.

Certain State Employees who are not covered by collective bargaining are eligible for Dental and Vision benefits that are offered primarily to managers, legislators, legislative staff, and certain Executive Office staff. All Employees of higher education, the Trial Court system, and authorities other than the Massachusetts Bay Transportation Authority are ineligible for Commission Dental and Vision coverage. Certain Massachusetts Bay Transportation Authority employees who are not covered by collective bargaining are eligible for Commission Dental and Vision coverage, as are certain confidential Employees. Employees may only change plans during Annual Enrollment, even if their dentist leaves the plan.

§ 9.23: Pre-tax Options for Commission Benefits

Employees' share of basic life and health insurance premiums may be deducted from their paychecks on a pre-tax basis, and may change the tax status of their premium deductions during Annual Enrollment or upon a qualifying event.

(1) Health Care Spending Account Program. Active State Employees who work at least 18.75 hours in a 37.5 hour work week or 20 hours in a 40-hour work week and are eligible for Health Coverage may arrange to pay for their out-of-pocket health care expenses on a pre-tax basis through the Commission's Health Care Spending Account program. State Employees pay a specified sum determined by the Commission by payroll deduction for non-covered health-related expenses. The Commission and the vendor(s) administering pre-tax options for Commission Employees establish the procedures, terms and conditions consistent with Internal Revenue Code rules. Such rules require that any unused funds in a participant's account at the plan's year end be forfeited.

(2) Dependent Care Assistance Program. Active State Employees who have employment-related dependent care expenses for Dependent children who are younger than 13 years old or are younger disabled adult dependents may pay for certain dependent care expenses through the Commission's Dependent Care Assistance Program. Participants elect an annual dollar amount per family to be taken as a payroll deduction, up to a maximum set by the Commission, to pay for qualified child and elder day care, after school programs, and day camp dependent care expenses.

§ 9.25: Appeals

(1) Any person who is aggrieved by a decision of the Commission, or by a final decision of one of the Commission's self-insured plan administrators about benefits may appeal in writing to the Commission's Executive Director. Benefits that are explicitly excluded from coverage in the plan of benefits are not appealable. The Executive Director shall consult with the Commission's General Counsel to determine whether the matter warrants presentment to the Commission's Appeals Committee. If presentment is warranted, the Executive Director shall enter the matter on the Commission's Appeals Docket for resolution via the Commission's appeals procedures. The Appeals Committee's decisions are final and binding, and may only be re-considered if new information that was unknowable at the time of the initial appeal to the Appeals Committee would alter the outcome of the appeal. Appellants may pend their appeals to the Commission up to a maximum of 120 days after their initial filing in order to obtain additional information. Appeals that exceed the 120 day period will be closed without prejudice to the appellant.

(2) Notwithstanding clause (1), the Executive Director may modify appeals procedures in order to achieve compliance with requirements of federal law, including but not limited to 42 U.S.C. § 300gg–19. To that end, Commission’s Executive Director may delegate external appeals procedures to the Commission’s self-insured plan administrators. If the Executive Director has delegated appeals procedures to one or more plan administrators, any person who is aggrieved by a decision of the Commission, or by a final decision of one of the Commission's self-insured plan administrators about benefits, may appeal in writing to the plan administrator.

(3) Notwithstanding clauses (1) and (2), eligibility decisions by the Commission are final and not subject to appeal procedures under this section.

§ 9.26: Health Insurance Buy-out Option

Insured State Employees and Insured State Retirees may buy out their Commission health coverage during Annual Enrollment or at a time designated by the Commission in the fall if they have other non-state health insurance coverage that is comparable to Commission health coverage and is verified by documentation acceptable to the Commission and must maintain Basic Life Insurance. Eligible Employees and Retirees receive 25% of the full-cost monthly premium in lieu of health insurance benefits for a maximum of one 12-month period starting either July 1 or January 1. Full cost monthly premium is determined based on the Employee's last Commission health plan and coverage type (individual vs. family), and is subject to applicable taxes.

§ 9.27: Long-term Disability Insurance

All active full-time and half-time State Employees who work at least 18.75 hours in a 37.5-hour work week or 20 hours in a 40-hour work week are eligible for Long-term Disability benefits. Active State Employees who are eligible for Basic Life Insurance coverage are eligible for the Commission's Long-term disability insurance program sponsored by the Commission. The conditions for participation, the amount of benefits and their duration, and the premium rates shall be jointly determined by the Commission and the Long-term Disability insurance carrier providing the Long-term Disability Insurance plan.

New State Employees may enroll in the Long-term Disability program within 31 days of hire without providing acceptable evidence of good health and thereafter may enroll in the program at any time by providing acceptable proof of good health to the Long-term Disability carrier.